IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006663

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paul Lawrie
Deceased:	Phyllis Joan Porter
Date of birth:	30 April 1949
Date of death:	12 December 2021
Cause of death:	1(a) LARGE RECTAL PROLAPSE AND ISCHAEMIC BOWEL
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084

INTRODUCTION

1. On 12 December 2021, Phyllis Joan Porter was 72 years old when she died at the Austin Hospital. At the time of her death, Phyllis lived in a Villa Maria aged care home at 75 Willow Bend, Bulleen, Victoria, 3105.

THE CORONIAL INVESTIGATION

2. Ms Porter's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Coroner Sarah Gebert initially had carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Phyllis's death. The Coroner's Investigator conducted inquiries on Coroner Gebert's behalf, including taking statements from witnesses – such as Ms Porter's family, care home staff, and the forensic pathologist – and submitted a coronial brief of evidence.

6. I took carriage of this matter in October 2022, for the purposes of finalising this finding.

7. This finding draws on the totality of the coronial investigation into the death of Phyllis Joan Porter including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

8. I note that the *Coroners Regulations 2019* (Vic) were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7, namely a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. Although Ms Porter was not, at the time of her death, a person 'in care' for the purposes of the *Coroners Act*[2], it is appropriate to have regard to the current requirements for the coronial process involving persons in care. These include the need for an inquest unless the coroner considers the death was due to natural causes and a requirement that the findings are published.

9. In the circumstances, I have considered it appropriate for the coronial process to proceed as though Ms Porter was a person 'in care' at the time of her death, save for the requirement for publication of these findings.

BACKGROUND

10. Ms Porter was born in Geelong on 30 April 1949 and grew up in a large family. She lived with an intellectual disability and had a history of significant concerning behaviours, including self-harm and obsessive-compulsive disorder. She was largely non-verbal and bilaterally hearing impaired, although she did not wear hearing aids by choice.

11. In 2000, Ms Porter was placed into the care of the Villa Maria Catholic Home in Bulleen and resided there until her death. The Villa Maria Catholic Home is an enrolled Specialist Disability Accommodation (**SDA**) dwelling and Ms Porter was an 'SDA resident'.[3]

12. By the final years of her life, Ms Porter suffered from a constellation of physical and mental health difficulties. These included: depression and anxiety, Type II diabetes, renal failure, hypertension, hyperthyroidism, dyslipidaemia, and rectal prolapse.

13. Ms Porter had suffered previous problems with rectal prolapse and was as an outpatient at the Austin Hospital on 17 September 2021. At that time, she had been waitlisted for a colonoscopy

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[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] s.3(1) *Coroners Act 2008*; r.7(1)(d) *Coroners Regulations 2019*.

[3] An 'SDA resident' is a person who is an 'SDA recipient' namely, a person who is an 'NDIS participant' funded to reside in an 'SDA enrolled dwelling': s.498B *Residential Tenancies Act 1997.* 'SDA enrolled dwelling' is defined at s.3(1) *Residential Tenancies Act 1997*.

and consideration of a Delorme's procedure for repair of the prolapse. The colonoscopy had been scheduled for 3 December 2021 but was cancelled by Austin Health.

14. The Office of the Public Advocate (**OPA**) acted to provide consent to medical treatment.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

15. On the morning of 12 December 2021, Ms Porter was found on the floor of her room. She was seen to have a large rectal prolapse and an ambulance was called. At 8.45am she arrived at the Emergency Department of the Austin Hospital.

16. Ms Porter's vital signs were poor – she was hypotensive and borderline tachycardic. On examination Ms Porter was found to have a section of small bowel visible that was noted to be 'dusky' (and therefore suggestive of ischaemia). Testing of her venous blood gas revealed severe metabolic acidosis.

17. Ms Porter was assessed by the surgical team, whose impression was that there was a prolapse of at least 80cm of non-viable small bowel. They noted that it is unusual to have a small bowel prolapse without history of abdominal surgery, and thought the likely pathology was erosion/necrosis of the rectal wall with perforation, allowing the small bowel to prolapse.

18. Given the high likelihood of a poor outcome even with surgery, a plan was made to manage Ms Porter palliatively. Dr Sarah Charlton (Acting Director of Palliative Care at Austin Health) stated that the surgical team left a message with the OPA but that there was no record of any further contact with them.

19. Ms Porter passed away at 7.19pm that evening.

20. Despite the ambiguity concerning contact with the OPA, I am satisfied that the decision taken by the medical staff at the Austin Hospital to provide palliative care on 12 December 2021 was appropriate.

21. I am also satisfied that there are no relevant issues concerning the care provided to Ms Porter at the Villa Maria Catholic Home.

Identity of the deceased

22. On 12 December 2021, Phyllis Joan Porter, born 30 April 1949, was visually identified by the House Supervisor at Villa Maria, Ms Porter's aged care facility, Rita Khudur.

23. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Forensic Pathologist, Dr Yeliena Baber of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 14 December 2021 and provided a written report of their findings dated 12 January 2022.

25. The post-mortem examination revealed findings in keeping with Ms Porter's clinical history. Examination of a post-mortem CT scan showed ischaemic bowel with gas in the small bowel wall, pneumoperitoneum, small peritoneal effusion, cardiomegaly, and metalwork to the right ulna and radius. Nothing abnormal was detected about the head and cervical spine.

26. Toxicological analysis of post-mortem samples identified the presence of fluoxetine, norfluoxetine, hydromorphone, paracetamol and lignocaine.

27. Dr Baber provided an opinion that the medical cause of death was 1 (a) LARGE RECTAL PROLAPSE AND ISCHAEMIC BOWEL. Dr Baber noted that on the basis of the information available to them at the time, their opinion was that Mr Porter's death was due to natural causes.

28. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Phyllis Joan Porter, born 30 April 1949;

    b) the death occurred on 12 December 2021 at Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084, from LARGE RECTAL PROLAPSE AND ISCHAEMIC BOWEL; and

    c) the death occurred in the circumstances described above.

I direct that a copy of this finding be provided to the following:

Patsy Porter, Senior Next of Kin

Robyn Shea, Austin Health

Villa Maria Catholic Homes

Constable Andrew Duffin, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 11 January 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.